



CHILD GUIDANCE CENTER

Helping kids find hope and healing

FAMILY HISTORY

Child's Name _____ DOB _____ CGC ID# _____

EMERGENCY INFORMATION

Child's Physician _____ Phone _____

Special Medications or medical treatment? _____

Allergies to medications (Please list) _____

Name of persons to notify in case of emergency _____ Phone _____

FAMILY MEMBERS (Current)

Biological mother _____ Biological father _____

Adults child is living with (if different than above)

Parent _____ Relationship to child _____

Parent _____ Relationship to child _____

Children

Name _____ Date of Birth _____ Age _____ In home? Yes No

School _____ Grade _____ Teacher _____

Name _____ Date of Birth _____ Age _____ In home? Yes No

School _____ Grade _____ Teacher _____

Name _____ Date of Birth _____ Age _____ In home? Yes No

School _____ Grade _____ Teacher _____

Name _____ Date of Birth _____ Age _____ In home? Yes No

School _____ Grade _____ Teacher _____

Name _____ Date of Birth _____ Age _____ In home? Yes No

School _____ Grade _____ Teacher _____

Others living in home

Name _____ Relationship to child _____

Name _____ Relationship to child _____

Name _____ Relationship to child _____

Marital History

Name _____ Spouse _____ Dates _____

Name _____ Spouse _____ Dates _____

Name _____ Spouse _____ Dates _____

Name _____ Spouse _____ Dates _____

Other significant persons in child's life

Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

Child's Placement History _____ From _____ To _____
_____ From _____ To _____
_____ From _____ To _____

Community Resources/Services (Please list any community resources or services with which your child or family is currently involved.)

DEVELOPMENTAL HISTORY (Please place a checkmark if there are or were difficulties or complications in the following areas.)

Pregnancy Labor/childbirth
 Premature/low birth weight Difficult temperament
 Crawling Walking
 Talking Toilet training
 Head injury Infant/early childhood illnesses or disorders
 Feeding Sleeping
 Difficulty with bonding, attachment Failure to thrive
 Fetal Alcohol Syndrome/Effects Difficulty bonding with parent/caretaker

Please indicate which types of child management techniques your family uses.

Time-out Restriction of privileges
 Verbal reprimands Spanking
 Discussion of expectations/consequences Grounding
 Yelling, lecturing Other _____

Which of these techniques, if any, have been most effective? _____

SOCIAL INFORMATION

Please list three of your child's favorite recreational activities, interests, or hobbies (e.g., sports, games, family activities, organizations, clubs).

1. _____
2. _____
3. _____
4. _____
5. _____

Please list any jobs or chores your child has.

1. _____
2. _____
3. _____

Please list your child's main strengths or best qualities.

- 1. _____
- 2. _____
- 3. _____

Please list your family's main strengths or best qualities.

- 1. _____
- 2. _____
- 3. _____

Please list your family's main sources of emotional support and/or assistance.

- 1. _____
- 2. _____
- 3. _____

ACADEMIC/SCHOOL HISTORY

School _____ From grade _____ to grade _____

School _____ From grade _____ to grade _____

School _____ From grade _____ to grade _____

School _____ From grade _____ to grade _____

Grades your child usually receives on report cards _____

Has your child been identified as:

- learning disabled
- developmentally disabled
- behaviorally disordered
- gifted
- Behavioral Skills Program

Please describe any difficulties your child is having in the school setting.

LEGAL HISTORY (Please check any law violations your child has been charged with.)

- Truancy
- Assault
- Theft
- Disturbing the peace
- Sexual assault
- Alcohol/drug related
- Vandalism
- Running away
- Shoplifting
- Other _____

Has your child ever been on probation or parole? Please explain and give dates.

Has your child ever been detained in a correctional setting? Please cite location and dates.

MENTAL HEALTH HISTORY (Please list any previous or current mental health or substance abuse services your child has received.)

Therapist/agency/hospital _____ When _____
Therapist/agency/hospital _____ When _____
Therapist/agency/hospital _____ When _____

If possible, please indicate any diagnoses that your child has received _____

Has your child ever taken medications for mental/emotional problems?

Name of medication _____ Physician _____

Please identify any history of emotional difficulties on either side of the child's family (e.g., depression, suicides, mood problems, anger control, anxiety, substance abuse, psychiatric hospitalizations, etc.)

Please list the things/events/problems that are creating the greatest degree of stress for your child/family at the present time.

1. _____
2. _____
3. _____

Please list the major goals that you have for your child/family in counseling.

1. _____
2. _____
3. _____

Signature of person completing this form _____

Relationship to child _____



PROBLEM/ISSUE CHECKLIST

Name of child _____ DOB _____ CGC ID# _____

Date _____ Person completing checklist _____

Please place a checkmark next to any of the following problems or concerns that your child may be experiencing.

Mood/depression problems or issues

- depression/withdrawal/crying spells
- loss of interest in activities
- fatigued, low energy level
- suicidal thoughts, actions, attempts
- low self-esteem, self-confidence
- harmful behaviors to self
- grief, loss issues

Emotional problems or issues

- sleep problems, nightmares
- anxiety, excessive worry
- panic attacks or intense fears
- anger or temper outbursts
- rapid or dramatic mood swings
- irritable
- isolates self or withdraws from others
- won't talk about what may be bothering him/her
- bed-wetting, soiling
- poor appetite or diet, eating disorder

Conduct problems or issues

- fighting with peers
- threatens to harm others
- stealing
- aggressive, assaultive behavior
- lying
- noncompliant, disrespectful
- cruelty to animals
- fire-setting
- sexual acting-out
- law violations
- drug/alcohol use
- doesn't follow curfew
- gang involvement

Impulse control problems or issues

- hyperactive, restless
- doesn't think before acting
- accident prone
- difficulty concentrating
- difficulty organizing tasks
- easily distracted, no follow-through
- takes many risks that may be dangerous

Thought problems or issues

- repeated actions child cannot stop (e.g., washing hands, counting things)
- disturbing thoughts child cannot stop
- problems remembering things
- odd, bizarre thoughts or actions
- sees or hears things others do not
- believes others are out to get him/her

Social/Personal problems or issues

- too shy, dependent on parents
- socially immature
- difficulty making and keeping friends
- hanging out with friends with whom you disapprove
- attention-seeking, whiny
- feelings hurt easily
- selfish, self-centered
- complains that others don't like him/her
- blames others for own problems
- difficulty adapting to new situations
- avoids trying new things
- follows the crowd, easily influenced by peers
- significant change in peer group

(Over)

School problems or issues

- truancy
- anxious about attending school
- suspended, expelled, detentions
- disruptive in the classroom
- difficulties getting along with classmates
- difficulties getting along with teachers
- problems in daycare setting
- learning disability
- behavioral disability
- trouble paying attention, listening
- not doing homework
- working below grade level
- speech, language, reading, writing disorder

Family problems or issues

- conflicts with mother/stepmother
- conflicts with father/stepfather
- fighting with siblings
- divorce/separation issues

- marital problems
- domestic violence
- parental substance abuse
- running away
- difficulty following rules, doing chores
- difficulty with basic routines
(e.g., hygiene, bedtime)
- experiencing racial/ethnic discrimination

Other problems/issues

- sexual abuse victim
- physical abuse victim
- emotional abuse victim
- frequent moves, changes in schools,
changes in placement
- death or loss of a loved one
- witnessed domestic violence

Please identify any other concerns that you may have with your child (or family).

problem list

05/06

